# Implementing improvements to health care services in the US

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Health Services Research, Health System Reform, Implementation Science, Overseas

In a previous blog I was critical of the US health care system for not using cost-effectiveness information to plan their services. Today I'm going to talk about the implementation of innovation in health services, something the US does really well compared to Australia.

The University of Michigan is the home for my sabbatical in 2015 and they lead many initiatives to improve the quality of care. Starting in 1997 there was an effort to reduce variation in angioplasty procedures and treatments. Since then improvements have been made for 18 other important health services http://www.valuepartnerships.com/vp-program/quality-collaborations/

Improvements for just six of these have led to cost saving of $600M per year and this outcome of 'cheaper and better' health services is a core value of AusHSI.

My impression is that successful implementation of innovation rests on these things (which I explain in detail below):

Making appropriate investments for the long-term

Getting the incentives right

Working at large scales and with good information

Involving university researchers and using scientific methods

A good case study is a now mature programme to improve prophylaxis for venous thromboembolism (VTE), a common and sometime deadly complication that is largely preventable. It has been implemented in 47 Michigan hospitals.

At the heart of the VTE innovation are 75 full-time and permanent positions at the 47 hospitals. These VTE specialists collect data on risk reduction activities and the outcomes achieved, typically they also set up a VTE committee and advocate for change to practice. They add large dollops of grease to the various cogs inside the implementation processes. But please don't think of it as a clean linear process. Implementation is highly complex with evidence, context and facilitation all required to make it happen. http://www.ncbi.nlm.nih.gov/pubmed/10185141 Having people in

permanent positions fully committed to reducing the problem is foresighted.

The economics are a no brainer, with the investment in a staff member paid off by the prevention of just a few extra cases of VTE. Presumably this is why Blue Cross and Blue Care, the insurance companies who fund this activity, made these investments. They are taking a long-term view for better patient outcomes and lower costs. In Australia our private insurers and the state and territory health departments might consider making these investments if they want better health outcomes and lower costs regarding VTE.

So there is pressure from below to reduce VTE. Pressure from above was applied via a financial payment made to the hospital by the insurers if they could meet the VTE target. Senior management among the hospital expected the full payment, and if there was some deduction due to poor VTE outcome people were hauled into offices to explain why. I don't know if anyone got sacked, but they were certainly given strong feedback. This might set up an incentive for gaming and fudging the data, but random independent audits of hospital VTE programmes did not find any fudging.

An interesting point is whether working at a large scale of 47 hospitals is essential. I suppose it could be implemented just as effectively at one site rather than at all 47 sites. But there are likely to be branding and publicity benefits from having a whole group of hospitals moving towards a common outcome. Maybe an element of competition arose between sites too, with many seeking to have the lowest rate.

Academics want to get involved in this partnership between insurers and hospitals because it offers an opportunity to publish important papers, attend scientific meetings and claim credit for changing the way health services are run.

My hosts at U Michigan regularly publish in JAMA, Annals of Internal Medicine and NEJM, the very best medical journals. Yes … academics are motivated by adulation from their peers and making changes of benefit; they want to have a legacy and they want to win more grant funding based on their track record.

While academics coordinated the whole VTE reduction project it was presented as a health services led project. I understood that putting academics at the front of these things was a turn off for insurers and hospitals. Rather they might want to claim the credit for themselves, but maybe to a different audience such as the media, politicians and patient advocacy groups. They also want the adulation of their peers and to win funding and influence in the future.

In Australia we could learn a lot from the US about the best way to do large-scale innovation in health services.

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